

Island View Dental
638 North Webb Rd
Grand Island, NE. 68803
(308) 381-0167/ Fax (308) 381-6689

PATIENT PAYMENT OPTIONS

Patient Name _____ Initial Date _____

Pre-Payment for Entire Treatment Plan: Total Treatment: \$ _____

- Total Treatment Plan, by Credit Card: \$500- \$1500= 3% Savings Total _____
- Total Treatment Plan, by Cash or Check: \$500- \$1500 = 5% Savings Total _____
- Total Treatment Plan, by Credit Card: \$ 1501+ = 7% Savings Total _____
- Total Treatment Plan, by Cash or Check \$1501+ + 10% Savings Total _____
- Practice will submit insurance for patient reimbursement

Pay as You Go for Each Treatment:

- Total patient responsibility (co pay) paid at time of service by cash, check or credit card

1/2 - 1/2

- 1/2 of total fee/ Co payment at first treatment Amount _____ Date _____
- Remaining 1/2 of total fee/ Co payment at agreed upon date Amount _____ Date _____

1/3 - 1/3 - 1/3

- 1/3 of Total Treatment Fee/ Co payment=Prepayment Amount _____ Date _____
- 1/3 of Total Treatment Fee/ Co payment at first Treatment date Amount _____ Date _____
- 1/3 of Total Treatment Fee/ Co payment at final Treatment Date Amount _____ Date _____

Payment over 3, 6, or 12 months (Interest Free) minimum of \$300

- 0% financing for 3, 6, or 12 months Monthly payment _____
- Practice pays the interest carried through for _____ months
- third-party company

Extended payment option (Interest Applies) minimum of \$1000

- The above company also offers 24, 36, 48, and 60 month payment plans
- Patient pays all interest

Total \$ _____

Estimated Patient Portion \$ _____ over _____ months

IMPORTANT: Insurance portion is an estimated amount. Payment may vary based upon the patient's deductible and plan limitations.

This is to certify the above treatment fees and checked payment option has been explained to me and I fully understand the nature of the treatment recommended. I understand and agree that if my insurance does not pay my insurance claim within 45 days, I am responsible for any balance due. I agree to pay reasonable attorney's fees, court costs and collection costs incurred by _____ in collection and enforcement of the debt. The above fees will be honored for 90 days or until commencement of treatment, whichever occurs first.

Accepted: _____ Date: _____

Financial Coordinator: _____